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ABSTRACT

An alcoholism recovery home was established for Mariel Cuban refugees, but client selection procedures and program were inappropriate. A viable alternative was found with Hispanic Alcoholics Anonymous, and the program was converted to this approach. Problems of professionalism and the clinical relationship to AA emerged. Clinical interventions are inappropriate in the AA context, but sociologists may adopt the ethnographer's role. Exploration of the transcultural adaptation of AA ideas for an Hispanic population proved therapeutic when clients were placed in roles such as collaborator and cultural informant. Sociologists involved with groups in which clinical roles are inappropriate may find subjective refuge in the role of ethnographic researcher.

Cross-cultural prevention and treatment of alcoholism are not new, but the development of viable programs for most unacculturated populations has been delayed due to funding agencies' lack of commitment and the absence of an effective, practical approach. Appropriate programs had to wait until the ethnic enclaves having alcoholism problems could evolve means for helping their own members overcome drinking. After that it became possible for clinical sociologists, using the "culture broker" approach (Hoffman, 1985; Weidman, 1975, 1983), to assist in the creation of cross-cultural programs to serve individuals who are not included in the ethnic enclaves.

Although alcoholism prevention and treatment exist for Hispanics in the United States, most such programs are designed to serve English-speaking or bilingual "Chicanos" and Puerto Ricans. The new Hispanic immigrants largely constitute an unserved population, ineligible for services due to their illegal status and undocumented residence. When 125,000 Hispanic immigrants sud-

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denly arrived in South Florida from the Cuban port of Mariel in Spring 1980, the need emerged for new forms of human services programs, among them alcoholism treatment.

Alcocer (1982) reported that Cuban immigrants seemed to have lower rates of problem drinking than other Hispanic populations, but this was based on study of immigrants who arrived prior to the Mariel influx. Page et al. (1985: 324) found an unusually strong pattern of denial of intoxication and habitual abuse among Cuban males, particularly among older Cuban males. Alcoholism among Cuban immigrants is a much greater problem than had been supposed.

As soon as the Mariel wave of Cuban immigration began, the Miami Mental Health Center's Substance Abuse Unit felt the impact. Amaya (1983:37) described the new arrivals:

> Some alcoholics arrived in Miami misdiagnosed, labeled as psychotic and brought straight from hospital beds to the dock involuntarily, and completely separated from their families. Others came to the boatlift straight from the prisons where they had been imprisoned for some crime committed while under the influence of alcohol or other drugs. The saddest cases were those who were manipulated to join the boatlift by their own families because the family was tired of their addictive behavior and wanted to get rid of them. There were also a few who managed to join the boatlift in a chemical blackout only to become aware of their situation when the alcohol or other drugs wore off and they found themselves in the middle of the ocean suffering from the effects of withdrawal.

These refugees' drinking problems progressed after they arrived in the host country. Sudden freedom was accompanied by loneliness, unfamiliarity with the language and customs, and unemployment. Thousands of refugees whose prospects for resettlement were poor remained in refugee camps and many, alcoholics and others, were turned out by their sponsors and compelled to live on the streets or returned to federal custody. According to Amaya, during the first year of the Marielitos' presence in Miami there occurred "at least 27 murders involving Mariels . . . in or around bars. Some of them were addicts who were so despondent over the condition they found themselves in that they set up circumstances to get themselves killed because of the pain they could no longer bear" (p. 38).

The Treatment Program: Beginnings and Problems

Southern California is another center of Hispanic immigration, but the Cuban ethnic enclave is much smaller and less important than the one in South Florida.

Mental health treatment is available for Hispanic Americans, but local government agencies are reluctant to provide social services for undocumented Hispanics who are in this country illegally. A few hundred Mariel Cubans have been sent to Southern California under federal programs for refugees whose prospects for sponsorship and success in the United States seemed poor due to physical or mental illness, old age or substance abuse. In the Fall of 1983, an alcoholism treatment program was established for institutionalized Mariel Cuban refugees in a psychiatric halfway house in East Los Angeles. Ten patients (nine males and one female) with diagnoses of primary or secondary alcoholism were chosen as the initial treatment population.

The program was initially designed along the lines of an "Alcoholism Recovery Home" with regular group therapy, individual counseling, "therapeutic games," alcohol education, recreation and pseudovocational activities. Four times a week residents' evenings were spent at meetings of Hispanic Alcoholics Anonymous groups. The clients were under 24-hour supervision by a social worker, program assistants, a paraprofessional alcoholism therapist, and a sociologist whose job title was "acculturation specialist." They were housed in a facility which was administratively linked with, but separate from, a larger psychiatric halfway house program for Cuban refugees.

After nine months' operation, it was clear that this very expensive alcoholism treatment program was a failure. The clients sat in stony silence through all the therapy sessions and games. They assimilated little or nothing of the alcoholism education. Some complained bitterly that they wanted to work and earn money, receive vocational training, or at least study English, and that alcoholism education was an irrelevant bore. Several clients pointed out that they had not had a drink for as long as 10 years, before beginning long stretches of institutionalization. It seemed to them that the therapists and program personnel were obsessed with alcohol. There were frequent relapses and (it was later learned) several clients managed to consume a couple of beers every day before breakfast despite the surveillance. Only a few clients ever admitted to their alcoholism, although several had their stay in the program extended due to repeated drinking incidents.

During these nine months the larger psychiatric program for Cuban refugees had undergone many changes. The paraprofessional alcoholism therapist came into conflict with the Licensed Clinical Social Worker who was also director of the larger program. The issue was the director's own drug abuse problems. The therapist was terminated but the director's post also soon fell vacant. The social worker became involved in the ensuing power struggle and was terminated when an opposing candidate took charge. The sociologist was called upon either to restructure the alcoholism treatment program or abolish it.

Analysis of Initial Program Failure

This nine-month start-up period was a useful learning experience for analyzing what was wrong with the recovery home approach when dealing with institutionalized refugees and for defining ways to restructure the alcoholism treatment program. The first difficulty was inappropriate selection of clients. Many residents of the larger psychiatric program had drinking problems but were not assigned to the alcoholism program due to vocational or other commitments which might have suffered. Others were assigned directly upon arrival after years of institutionalization in federal prison or a maximum security mental hospital. Such institutionalization followed years in Cuban jails so that, in one case, 14 years had passed since the client had had an opportunity to take a drink. Since this client was only 28 years old, his diagnosis of primary alcoholism was very questionable. Several alcoholic clients were unable to benefit from the program's didactic approach due to organicity. Neither staff nor residents were taking the alcoholism treatment program seriously.

It seemed that the only program activities which had any therapeutic impact were the Alcoholics Anonymous meetings. Two in-house meetings were conducted by members of the Hispanic Alcoholics Anonymous Institutions Committee each week and the clients were also taken to two meetings in the community. These activities had elicited a certain amount of interest and participation from the clients, whereas no other program activity had aroused anything more than boredom and hostility.

Establishment of the Hispanic AA Group

In the Spanish-speaking communities of Los Angeles, Alcoholics Anonymous is a rapidly growing organization, with over 100 groups in operation. Hispanic AA follows the 12 AA Traditions for functioning groups of the original Anglo organization and urges members to use the 12-step program for personal recovery from alcoholism. All literature is translated from literature approved by the New York office. AA groups seek to help members promote their own recovery by admitting that drinking has made them lose control over their lives, trusting in a "higher power" than themselves, taking an inventory of their personal faults, making amends to those they have harmed and helping alcoholics who want to stop drinking.

The alcoholism program was restructured around and in cooperation with the Hispanic branch of Alcoholics Anonymous. The components which had been borrowed from conventional recovery homes—the group therapy, the personality games ("positive me exercises," etc.), the alcoholism education, the separate residential facility, and the fruitless attempts to persuade unwilling or illiterate clients to write out personal inventories—were all abandoned. The new program

director insisted that the alcoholism program no longer be called a "treatment program" since the traditional elements of alcoholism treatment had been abandoned. She wanted it called "the Alcoholism Prevention Unit" and this name stuck even though there were no components of traditional alcoholism prevention programs. "Alcoholics Anonymous is also for prevention," is a phrase which is commonly heard in Hispanic AA groups, so the sociologist did not think it necessary to engage in polemics over the name. Staff of the alcoholism unit refer to their activities as "the Alcoholism Program." This name was then given to the residents' AA group which was formed later.

The alcoholism recovery home staff was disbanded and transferred to other duties, leaving the sociologist to conduct program activities without help or interference. The new program functioned in the evening, which meant that alcoholic clients who worked during the day could now attend. Residents who presented drinking problems were assigned to attend by their counselors, but the sociologist tried to develop voluntary participation by treating the opportunity to attend meetings as an "outing" or a festive occasion.

The Sociologist's Role

The sociologist, who has not accepted personal defeat by alcohol, is in a marginal condition with regard to membership in Alcoholics Anonymous. However, sociologists are trained to be alert to the unstudied population, to the unseen social phenomenon which is worthy of research attention. In this case the unstudied phenomenon was the transcultural adaptation of the Alcoholics Anonymous program and philosophy to help Hispanic alcoholics. The sociologist adopted the role of the participant observer and ceased acting as a therapist while attending the AA meetings. To the Hispanic AA members in the groups he looked like a driver who was in charge of getting the participants to the groups and taking them home afterwards. Overt acts of supervision in public were reduced to a minimum. Throughout this period the larger program was in turmoil due to power struggles and executive incompetence so the sociologist was free to develop the work of the alcoholism program without interference.

Attendance at AA meetings in the community became the central focus of the restructured program although there were still two in-house institutional meetings each week. Clients were encouraged to participate in structuring program activities and making decisions. For example, whenever an outing was scheduled to an AA meeting in the community, clients would be asked which meeting they wished to attend. The decision would be made on the basis of this preference. Seeing himself as a participant observer, the sociologist tended to treat the clients as helpers and informants rather than as patients. Since he is obviously a "gringo," clients' help in relating to other groups was welcome. It became possible to set aside the mental patient role, at least for those clients

who sincerely related to the AA program. However, it was not always possible to get out of the role of social controller for some of the more disturbed residents.

The Residents' Own AA Group

Before long it became clear that the clients would benefit from an AA group they could call their own. One of the goals of the program was to enable the clients to establish friendly, nonalcoholic relationships with members of the Hispanic community. When clients set out to do this at AA meetings, one of the first questions they encountered was: "What group are you from?" A truthful response of the form: "We are from a psychiatric halfway house for Mariel Cubans," would not enhance effective interaction. In fact, most of the clients had no response when confronted with such a question. A more suitable way for the clients to present themselves was needed.

The Hispanic AA Institutions Committee's workers had been able to stress the first step in the AA program: the admission that one's life has become ungovernable due to alcohol abuse. Several of the other steps were also presented, but it is very difficult for an institutional group to work through all 12 of the steps, particularly the last one which involves taking the AA message to alcoholics who still suffer. By operating a group within the "Traditions" it would become possible for those who were ready to work the steps to do so.

One evening during an in-house meeting conducted by members of the AA Institutions Committee, the suggestion was made that the residents might start their own independent group. Hearty agreement was aroused in several Cubans who had accepted the AA program, and they began to discuss the prospect excitedly. The Institutions Committee member soon had second thoughts about his optimistic suggestion that unemployed mental patients could start their own autonomous group, but there was no taking it back. The sociologist facilitated an arrangement to use a building owned by the city for very nominal cost and the clients pooled some of their spending money to start things off.

Establishment of a traditional AA group was a challenge which involved overcoming some of the habits of dependency into which these Cuban refugees had fallen. The objectives were "empowerment" in that residents would have an AA group to invite others to and to provide a definition of self as an AA member with roots in a group rather than as a mental patient. AA Tradition Number Seven requires that each group maintain itself from its own resources—members' contributions. The members arrange their own affairs in accordance with AA traditions, making decisions about expenditures and celebrations without consulting their social workers or the direction of the larger program. Of course the sociologist is still there to offer advice, which is not always taken. The group is open to anyone and is authorized to certify that drunk drivers referred by the courts have attended AA meetings. As many as six persons

from the community have attended on a given night and three attend more or less regularly.

The residents' AA group has recently completed its first anniversary. Two members have completed a year's sobriety and have had their anniversary celebrations as well. Five or six others have accepted the AA program and are working the steps to the best of their ability. Another half dozen attend AA whenever they want and have stopped drinking. Ten or 12 residents of the psychiatric facility have occasional drinking episodes and, when they do, are assigned to attend AA meetings for a while. Ten others have run away from the program and it is not known whether they are drinking or not. Four have found employment and have been discharged from the program. At least one of these still has serious drinking problems. While the results are imperfect, they represent an advance over the previous program.

The residents' AA group maintains as much separation as possible from the psychiatric program. When a client has a drinking episode, he or she is given a card resembling those given drunken drivers by the courts. The resident may take the card to any AA meeting and have it stamped. Most residents who are given cards attend the residents' AA group, but some prefer to attend other groups in the community. Attendance is therefore voluntary and any coercion involved comes from elsewhere, not from the AA group itself. The residents' group meets three nights a week.

The participants in AA activities are nearly all males. This reflects the composition of the psychiatric population of Mariel Cubans in the larger program. No females participate in the alcoholism program regularly although one of the four female residents attends AA meetings occasionally. Members' ages range from 25 to 68 years old. Several of the members exhibit some degree of organicity, and more than half are developmentally disabled.

Shortly before the residents established their own group it was decided to enlarge the alcoholism program. A recovering alcoholic from the Hispanic AA Institutions Committee was hired by the psychiatric program and given the task of transporting residents to AA meetings in the community. Activities were scheduled for seven nights a week instead of four. One vehicle proved too small to transport all those who wished to attend AA so two more recovering alcoholics were hired. At present, as many as 25 residents are transported to AA meetings in the community each evening. The sessions of the residents' group are held a few blocks from the psychiatric facility so most members walk.

Not all has been smooth going, however. Some residents resented the fact that the psychiatric program would require them to attend AA meetings after a drinking bout. Several alcoholics who had understood the AA philosophy without accepting it phrased their complaints in convenient rhetoric and expressed their discontent from the "tribuna" or speaker's platform. This seemed harmless until one man began to accuse the sociologist and the employees responsible for

transporting and supervising visits to groups in the community of "selling the message."

AA and Professional Roles

In English-speaking AA, the relationship of professionals and paraprofessionals working in alcoholism programs has been clarified. Recovering alcoholics who are AA members can work in alcoholism treatment and prevention but they should not misuse the name of AA. But treatment of alcoholic Hispanics is a relatively new field and Hispanic 12th step workers who maintain their own sobriety by helping others may develop resentments at seeing others getting paid for engaging in rather similar activities. The disgruntled client, who may have been seeking to protect his own drinking, struck a responsive chord in a group run by Central Americans, some of whom were antagonistic to the privileges of Cuban entrants receiving federal resettlement assistance. The sociologist's residual clinical role came under fire as he became the focus of "terapia dura" (confrontive therapy) at a meeting of this group. The sociologist had, for some time, sought to downplay this clinical role in relations with residents attending AA meetings, so the confrontation seemed somewhat misdirected. On the other hand, the participant observer received rich inputs of new data, some of it emotionally charged. It was an uncomfortable learning experience. Program philosophy and procedures were reassessed and the AA literature was searched for precedents and explanations. Fortunately, the English-speaking organization had experienced similar controversy and ample discussion is available (AA, 1957: 109–110). The issue is not professionalism, but anonymity. Of course AA members can work in treatment programs. But AA's name must not be used for fundraising or publicity. Provided the name of Alcoholics Anonymous was not misused we were not doing anything objectionable.

The Sociological Clinician

Straus (1984) points out that sociological intervention at the personal level may involve "directing clients to appropriate support networks to reinforce their definitions, or to peer self-help groups to help them reconstruct their realities outside of a therapy framework" (p. 56).

Borman (1983) notes that human service professionals and researchers have a special role in assisting in the formation of self-help groups and also in learning from them. According to Borman, the helping mechanisms of Alcoholics Anonymous are universality and acceptance, communication, social support, and response to both informational and emotional needs of the clients. "This occurs in settings which are non-coercive, non-threatening, and under the control and management of peers" (p. 105). Altruism—the helper therapy principle—is

another beneficial mechanism, in addition to the sharing of common values, development of a sense of hope and having opportunities to talk at great length with others like yourself. One of the reasons these helping mechanisms are too often ignored by conventional therapists is that they do not really require a therapist's involvement. While professionals have frequently played important roles in the formation and development of peer self-help groups, they do not have integral functions in the groups' helping processes.

Brody (1983) examines the contradictory position of the clinician as researcher who seeks to broaden knowledge of the relationships between culture, illness, and healing. Noting that praxis is an "indispensable element" which "characterizes the production of clinical knowledge" (p. 296), Brody explores the uses of the clinical role to obtain cultural information. Noting that fieldwork is a confrontation involving an inevitable disruption of the sense of self, he argues that "clinical work, as well as clinical status, may protect the professional helper from the shift in subjective reality experienced by the anthropologist struggling for acceptance and a new equilibrium in a strange setting."

Pollner and Emerson (1983) point out that "the major threat to observation derives from pressures that dissolve the stance of 'mere observer' by according the researcher some more consequential presence in the ongoing scene. This occurs when fieldworkers become incorporated, for a variety of reasons, into the ongoing social life in some central and consequential way" (p. 236). The authors point to responses that involve full participation on the behavioral level, but withdrawal and distance on the subjective level.

The problem of subjective distance and withdrawal was even more acute for a sociologist charged with developing an effective alcoholism treatment program—especially when analysis of available resources showed that Hispanic Alcoholics Anonymous could provide highly effective assistance. How could the sociologist rationalize his presence at nightly AA meetings? Professional therapists have no legitimate role in developing AA groups. Listening to the histories and testimonials of clients and other AA members with therapeutic intent is inappropriate. Such confessions are expressed for the speakers' benefit and for the benefit of alcoholics in recuperation, not for the purposes of clinical intervention, charting of clients' progress or maintenance of discipline in a psychiatric program. Research on the growth and development of AA as an institution is more appropriate, provided the research focus is on open, public AA meetings. Thus, the subjective stance of a researcher interested in group development and in the transcultural adaptation of AA ideology was useful for handling the dialectic between involvement and detachment. The initial absence of a preliminary struggle for personal equilibrium, of difficulty in finding acceptance and becoming a participant in the society observed, had left anxieties and unresolved conflicts which were exacerbated by the fact that clinicians, as such, do not have a legitimate role in the AA community. Consciousness of the research role made

it possible to adopt a more honest personal attitude toward participation in AA and to explain separation from some of AA's central values.

By developing a program approach that would allow for changes in the residents' definition of self and situation from that of coerced inmates of a recovery home to that of (mostly) voluntary participants in an autonomous program, resistance to alcoholism treatment was to some extent overcome. Some radical changes in human relations interventions were necessary, including separation of the residents' AA group from the alcoholism program's interventions in the larger psychiatric program. Thus residents' anonymity in AA meetings had to be respected, even when they might confess to breaking the rules of the psychiatric program.

During the reorganization, the alcoholism program underwent very high staff turnover. The sociologist's job title changed temporarily from "acculturation specialist" to "alcoholism program supervisor." The participant observer role was acknowledged to the recovering alcoholics who were hired to assist with the reorganized program and to colleagues in the academic community, but not to the succession of directors of the strife-torn larger program. After a time the alcoholism program seemed almost to run itself, at least to the extent that the sociologist no longer had to attend so many AA meetings. The "acculturation specialist" role reemerged, and there was also time for reflection on the Hispanic AA experience, writing up the ethnographic data and interviewing the large number of informants developed during participant observation at Hispanic AA meetings.

This intervention did not focus on providing treatment to individuals, but on development of a new, semi-autonomous program which could act as a vehicle for clients to empower themselves by adopting the ideas and practice of the Alcoholics Anonymous self-help movement. Those who failed to relate to AA and who continued drinking fell under the sanctions of the larger program, but the alcoholism program did not coerce anyone to attend meetings. The sociologist felt the need for a subjective refuge in the role of ethnographic researcher while attending meetings at which clinical roles were inappropriate. The psychiatric patients were thus promoted to the status of informants and subjects of research on the process of transcultural adaptation of the AA program to serve Hispanic populations.

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